TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Hulsey Therapy Services

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-17-0310-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 3, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This patient did not report the claim as a worker's compensation claim or an injury on the job when she initiated treatment or during the course of her treatment. …It was only upon receiving a refund request from the Rawlings company on behalf of Aetna that we learned a worker's compensation claim had been filed regarding her injury. This refund request was received on 6-3-16 and included the claim information for Texas Mutual. We called Texas Mutual who verified the claim for this injury and were advised to submit a letter advising the reason for late filing of the claims. Texas Mutual paid the evaluation charge, but denied all other charges due to non-authorization of treatment."

Amount in Dispute: $2,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester provided physical therapy on the dates above and then billed Texas Mutual for this. Upon receipt of the bill Texas Mutual reviewed the billing and attached documentation, and then reviewed the claim file for any preauthorization record applicable to the dates of service. Finding no evidence preauthorization was sought or granted, Texas Mutual denied payment consistent with Rule 134.600(p)(5)(A)."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 31, 2016 through April 29, 2016	Physical therapy services	$2,000.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the requirements for prior authorization.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent
   - 930 – Pre-authorization required, reimbursement denied
   - 246 – This non-payable code is for required reporting only
   - 652 – This procedure code is used for reporting purposes only. No payment is due

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking $2,000.00 for physical therapy services rendered from March 31, 2016 through April 29, 2016. The insurance carrier denied disputed services with claim adjustment reason code 197 – "Precertification/authorization/notification absent" and 930 – "Pre-authorization required, reimbursement denied."

28 Texas Administrative Code §134.600 (p)(5) states in pertinent part,

> Non-emergency health care requiring preauthorization includes:
>
> (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:
>
> (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
>
> (i) Modalities, both supervised and constant attendance;
>
> (ii) Therapeutic procedures, excluding work hardening and work conditioning;
>
> (iii) Orthotics/Prosthetics Management;
>
> (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and
>
> (B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;
>
> (C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:
>
> (i) the date of injury; or
>
> (ii) a surgical intervention previously preauthorized by the insurance carrier;

Review of the attached documentation finds:

- The reported date of injury, December 6, 2015
- Date of knee surgery, March 22, 2016

The initial therapy began on March 31, 2016. This date is later than two weeks from the date of injury of December 6, 2015.

While the claimant had a surgical intervention on March 22, 2016, insufficient evidence found to support that the carrier preauthorized this surgery.

The Division did consider that the services in dispute were submitted to the claimant's health insurance plan based on the information provided at the time of admission. However, the requirements of Rule 134.600(p)(5)

do not allow for any exception of the prior authorization requirement other than those listed above. The carrier's denial is supported.

2. Based on the requirements of Division Rules no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		November 3, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.